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TESTIMONY OF JAN VANTASSEL, ESQ.
APPROPRIATIONS COMMITTEE
DMHAS BUDGET
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My name is Jan VanTassel, and I am the Executive Director of the Connecticut Legal Rights Project (CLRP), a statewide non-profit agency which provides free legal services to low income adults with psychiatric disabilities.

I want to open my remarks by noting that there are some positive elements in the DMHAS budget proposed by the Governor; the closure of Cedarcrest Hospital and funding for the anticipated caseload increase in young adult services. As the director of an organization which prioritizes enforcing the community integration mandate of the Americans with Disabilities Act, and protecting the rights of young adults to age appropriate services, I strongly support both of these proposals.

Unfortunately, they are packaged in an overall budget which reduces funds for community services, has no funds for housing, and proposes to spend millions of dollars on renovations to add new beds at CVH. Therefore, there are serious questions about the priorities reflected in this budget.

Let me start with the cuts in community services. There is a reduction of roughly $8.6 million over two years in community services. They are described as being generated through various service conversions, efficiencies and improvements in service delivery models. I am concerned for two reasons. First, these euphemisms make me uncomfortable because at the end of the day, they appear to be cuts to a system that is already inadequate to meet the client demand. Second, the Commissioner has consistently argued the need for additional housing and community services to help alleviate the "near paralysis" in the mental health system. This budget has neither.

One of the reasons that I support the closure of Cedarcrest Hospital is because there are far too many people in state facilities solely because the state lacks the housing and community services that they need to be safely discharged. They are not a danger to self or others, but what the court calls, "gravely disabled," legalese for saying there is no place for them to go. DMHAS consistently estimates that this includes 25%-33% of the Cedarcrest patients.
The state must find resources for desperately needed community services and housing, particularly supportive housing. However, this budget would have the state invest in renovations to add thirty beds at CVH, rather than invest in housing and community integration. This is troubling since the state routinely places individuals at DMHAS facilities who do not fall within the department's target population of persons with severe and persistent mental illness. This diverts resources from DMHAS clients, distorts the data regarding resources for persons with mental illness and interferes with the department's fundamental mission.

One twenty bed unit at CVH is dedicated to persons with Aquired or Traumatic Brain Injury (ABI/TBI) a diagnosis which does not fall within the DMHAS target population. There is funding in the budget for seventeen community placements for DMHAS patients with acquired brain injury or traumatic brain injury. The state should proceed with these community placements, but should amend the ABI/TBI Medicaid waiver, which currently has a waiting list, to obtain federal reimbursements for their services. In addition, DMHAS must assure that these beds are utilized only for persons with severe and persistent mental illness. It is quite possible that this twenty bed unit could be used for Cedarcrest patients rather than initiate costly renovations.

In addition, another CVH unit is used predominately for persons with medically fragile conditions that may not require treatment in a psychiatric facility. For example, there were two patients with end stage lung cancer who could have been treated in hospice programs. There are also several patients at CVH diagnosed with dementia, which is not with the department's target population. Again, less costly and more appropriate settings should be explored for these patients before the state invests its limited resources in building and staffing more inpatient beds at CVH. By focusing utilization on the DMHAS target population and assuring timely discharges to less restrictive settings, CVH could absorb the Cedarcrest beds, and address the lack of sufficient community placements by assigning state employees to those activities.

The lack of funds in the DMHAS budget for community integration, and I do not consider two fifteen bed "mini-institutions" to be community integration, is very disturbing. The failure to fund supportive housing is particularly troubling. As many of you know, supportive housing is an evidence based model that has been demonstrated to reduce state costs for hospitalizations and emergency room visits, increase the tenants' stability and participation in education and employment activities, and contribute to increases in neighborhood property values. It is proven solution to reverse a crisis-oriented mental health system. Yet the Governor stopped the grant awards to fund 150 new units that were shovel ready, and has no funds in this budget for any housing.

There is no hope of alleviating the gridlock in the state's mental health system when the only focus is on beds. CLRP encourages this committee to consider ways in which the state can redirect resources to the community mental health system, particularly through the maximization of Medicaid revenue. There are community mental health services currently state funded that would qualify for Medicaid reimbursement. The most obvious are assertive community treatment and community support services, which have already been developed for the Medicaid waiver for persons with mental illness. There is also potential for federal revenue which could be generated through mobile crisis and housing support services. A consultant's report issued in February, 2004 estimated that nearly $28 million could be generated by billing them to Medicaid. In addition, the state can pursue establishing a new level of intermediate care to be provided by private hospitals able to meet rehabilitation and discharge criteria, and be reimbursable under the Medicaid program.

I must note that implementing these changes may not generate significant immediate savings, and that there are state services that would not qualify for Medicaid funds that would require ongoing state grants. Nonetheless, this is an approach that warrants further exploration as a mechanism to fund the community mental health system and alleviate gridlock in the mental health system. I urge the committee to consider these, and would be very interested in discussing them further with you.